MARIAH MOHAMAD

v.

ABDULLAH DAUD & ORS.

HIGH COURT MALAYA, KOTA BHARU
ABDUL MALEK AHMAD J
[CIVIL SUIT NO. 254 OF 1983]
21 AUGUST 1989

TORT: *Fatal Accident - Claims by administratrix - Contributory negligence of deceased - Liability of doctors.*

The plaintiff's husband (deceased) aged 42 was riding a bicycle when he was involved in a collision with the car driven by the defendant on 31 January 1981. The defendant alleged that the deceased swerved suddenly on to his path. The deceased suffered head injuries and was admitted to a hospital in Kota Bharu. He was discharged from hospital on 28 February 1981 and re-admitted on 25 April 1981. He was subsequently discharged on 30 June 1981 and passed away on 18 July 1981.

The plaintiff had 5 children at the time of the accident ranging from the ages of 9 years to 16 years.

The deceased worked at Telecoms with a monthly salary of RM365. He gave the plaintiff RM300 a month. Of this amount, RM50 was used towards the deceased and RM250 for the plaintiff and her children.

The plaintiff spent RM500 on funeral expenses and RM300 for grants of letters of administration. She alleged that the bicycle valued at RM100 was totally wrecked and claimed RM150 for 15 hospital visits. The plaintiff had since remarried in 1985 and receives RM150 a month from her husband. She is also the recipient of the deceased's pension of RM70 per month.

Held:

[1] The Court made the following awards.

(a) *Special damages*

(i) RM500 for funeral expenses on the grounds that it was a reasonable and appropriate amount for a Muslim funeral.

(ii) RM350 for letters of administration - being the usual figure.

(iii) RM36 for actual expenses re: medical and police reports based on the receipts produced.

(iv) RM100 for the bicycle - being a fair amount although apart from the plaintiff's testimony there was no other evidence in respect of the damage.

(v) RM150 for transport expenses.

(b) *General damages*

(i) Loss of expectation of life - RM6,000 - figure agreed to by Counsel for plaintiff and defendant.

(ii) Lost years - RM31,150
(Multiplicand - RM366)
Multiplier - 9 (i.e. 55 minus 42 less 1/3 for contingency)

(iii) Pain and suffering - RM15,000 for a period of 5 months and 18 days.

(c) *Interest*

(i) 4% - on special damages from date of accident to date of judgment.

(ii) 8% - on general damages except for lost years - from date of service of writ to date of judgment.

[2] The defendant was 40% liable because the defendant had noticed the deceased from a distance of 60 feet away, which was a sufficient distance for the defendant to have anticipated the possibility of the deceased cutting across and to have been able to avoid the collision. The deceased was 60% liable because the accident would not have occurred if he had not cut across in that manner.

[3] In respect of the cause of death, the 1st and 3rd party was wrongly cited because they were not involved in the active management of the deceased.

[4] The 3rd party was not negligent because no evidence was adduced to show that the doctors concerned had departed from the approved practice in treating the deceased.

Cases referred to:
Teoh Kim Seng v. Hassan bin Mohamed & Anor. [1987] CLJ (Rep) 390
Thangavelu v. Chia Kok Bin [1981] CLJ (Rep) 281
Ho Kiong Chan v. Patipet [1966] 1 MLJ 1593
Chan Peng Fook v. Kan Pak Lee [1974] 2 MLJ 197
Joginder Kaur & Anor. v. Malayan Banking Ltd. & Anor. [1971] 1 MLJ 98
Lanphier v. Phipos [1838] C & P 475
Rich v. Pierpont [1862] 3 F & F 35
Hunter v. Hanley [1955] SC 200
R. v. Bateman [1925] 94 LJ KB 791
Clark v. MacLennan & Anor. [1983] 1 All ER 416
Bolam v. Frier Hospital Management Committee [1957] 1 WLR 583

For the plaintiff - Mahmood Adam; M/s. Mahmood Adam, Wan Ismail & Co.
For the defendant - Siva Dharma; M/s. Matthew Thomas & Co.
For the third party - Daphne Sebastian & Kang Hwee Ghee of the Attorney-General Chambers

JUDGMENT

Abdul Malek Ahmad J:

This matter first came up before me on 23 July 1985 but in view of the defendant's application then to issue a third party notice against the third party and subsequently his application for time to serve the said notice, the hearing could only commence on 16 September 1987. On that date, the plaintiff and the defendant gave evidence but the matter had to be adjourned as the defendant's witness could not be present. On 12 December 1987, both the defendant's witness and the second third party's first witness testified but the trial had to be postponed as the first third party was not present and the second third party's second witness was away in India. The matter was then fixed on 21 November 1988 for an application by the third party by way of summons-in-chambers to amend their pleadings to include the limitation clause under the Public Authorities Protection Act 1948 but because of floods, only Counsel

for the defendant was present and the summons-in-chambers was also on the next day withdrawn by the third party in view of a Supreme Court decision on the same point that same week. The case was then postponed to 28 March 1989 when the trial finally came to an end.

The plaintiff (PW1) had told the Court that she was in confinement when her husband was injured in an accident on 31 January 1981 and did not know how the collision took place. She also did not look after her husband while he was unconscious in hospital for six months before he passed away on 18 July 1981. At the time of the accident, she had five children ranging in age from 9 years to 16 days.

She also gave evidence that her husband had worked at Telecoms with a monthly salary of RM365 and that he used to give her RM300 a month as he usually ate at home. She explained that RM50 was for her husband and RM250 for her and the children. PW1 also stated that she spent RM500 for funeral expenses and RM300 for the grant of letters of administration. She added that her husband's bicycle valued at RM100 was totally wrecked and that she had incurred RM150 for the fifteen hospital visits.

She disputed the cause of death as "sakit biasa" and insisted that it was due to the accident. She had lodged her police report two years after the accident as she was in confinement at the time of the accident. She further told the Court that she had remarried in 1985 to a construction labourer who earned RM10 per day and who gave her RM150 a month on the average. She is also receiving her deceased husband's pension of RM70 per month.

PW1 also testified that her late husband was restless all the time and tied for some time lying down while in hospital and at home. He could not walk on his own and could not talk. He could not eat and was fed through tubes and he could urinate only through condom drainage. He was finally discharged on 30 June 1981 and according to PW1, the doctor had told her mother to treat the plaintiff's husband at home. From the discharge up to his death on 18 July 1981, PW1 said his condition did not change and in fact he was getting worse.

The defendant (DW1) told the Court that he was driving from Kota Bharu to Bulatan Wakaf Siku on 31 January 1981 in the lane nearer the left side of the road at 40 kilometers per hour when a cyclist on his left suddenly crossed in front of him. DW1 said he sounded his horn and swerved to the right but could not avoid the accident. The cyclist was flung onto the car bonnet. DW1 also said that before that he had seen the cyclist 60 feet away cycling in a normal manner but had crossed when he was 30 feet away. DW1 further told the Court that he had also applied his brakes hard to avoid the collision.

The defendant's witness was Dr. N. Arumugasamy (DW2) who was formerly head of surgery at the Kuala Lumpur General Hospital from 1969 to 1985 after receiving neurosurgery training in the United States from 1964 to 1969. According to DW2, he had perused the case notes of the deceased in November 1987 and had prepared his report dated 13 November 1987. He was of the opinion that the patient should never have been discharged under those conditions and that a computer axial tomogram scan (hereinafter "CAT scan") ought to have been done to get further information, as regards the blood clot and state of fluids in the brain, to further manage the patient. He said that if that had been done, a more definitive approach could have been taken. DW2 was then the head of surgery in the Kuala Lumpur General Hospital and he said that all CAT scan cases from all over the country where there were no such facilities were referred to him. The exploratory burr holes which were done, he said, was only exploratory to exclude the possibility of a blood clot.

DW2 added that with the notes he had and without a postmortem, he could not state with certainty the cause of death. His view was that the patient should not have been discharged on both discharge dates as the notes stated that the patient was irritable, disoriented and drowsy. He agreed, however, that if all investigations had ruled out the presence of structural abnormality responsible for that state, it was all right to discharge the patient provided he had proper nursing care. He felt that the patient should have been transferred to a better centre with better facilities like Kuala Lumpur which was the practice then as one-third or half of over a thousand head injury cases a year in Kuala Lumpur were from outside Kuala Lumpur.

The relevant medical officer in charge of the patient, Dr. A. Ramachandran (TPW1) gave evidence that the deceased's head chart, which monitors conscious level, pupillary reaction, temperature, respiration, blood pressure and pulse, was steady and that there were no abnormal signs in the nervous system. He had prescribed intramuscular valium to quieten restlessness, common for head injury patients, but had subsequently discontinued the *Manitol* drug and had given *Nootropil* instead to activate the central nervous system.

Between 31 January 1981 and 28 February 1981, TPW1 stated that there were no manifestations of a blood clot but conceded that the possibility was always present. He added that another doctor, Dr. Annamalai, was responsible for the deceased's first discharge. He, however, said that he would have done same thing as there was no deterioration to the condition and that there were signs of improvement. The question of a CAT scan, he said, then did not arise as the facilities were not available in Kota Bharu.

TPW1 went on to say that the deceased was readmitted on 25 April 1981. Under cross-examination by plaintiff's Counsel, TPW1 stated that the deceased's condition was better on the first discharge and he agreed with the first third party that there was no improvement on the second discharge. As regards the cause of death, TPW1 told the Court that it could have been due to the head injuries and that he could have been saved if there was a CAT scan. He explained that the patient was not sent to Kuala Lumpur for a CAT scan as there were many other similar cases where they did not do so. They would have sent if there was no improvement but here he said there was. He also that said there was a note to call Kuala Lumpur as regards the CAT scan but apparently there was no follow-up.

The first third party (TPW2) testified that he was attached to the Orthopaedic Unit of the General Hospital Kota Bharu in 1981 and was aware of the deceased's second admission but stated that he was not involved in the active management of treatment of the deceased despite his signatures appearing in the records. This was because, he said, he used to accompany Dr. Annamalai the orthopaedic consultant on his rounds. He maintained, however, that he was not responsible for the deceased's second discharge on 30 June 1981.

TPW2 reiterated that he was only involved in the deceased's conservative treatment namely the administration of intravenous drips, physiotherapy and the like. He did not recommend the CAT scan nor follow-up on the note to call Kuala Lumpur for such at p. 55 of C. He added that from the time of the second admission to the date of the second discharge the deceased never improved. There was also no purpose in doing the CAT scan as the exploratory burr holes had been done when it was discovered that the damage to the brain at the time of the accident was permanent.

The witness further stated that the deceased was referred to the psychiatric unit for assessment which unit diagnosed it as post traumatic psychosis. To rule that out, TPW2 said the exploratory burr holes were done upon which no lesion or blood clot was found in the brain, that is, no subdural haematoma was found as opposed to an intracerebellar blood clot in the brain.

The third party's last witnesses Dr. A. Annamalai (TPW3), an orthopaedic surgeon since 1975, stated that he had been treating head injuries since 1979. He said that he did not see the deceased on his first admission on 31 January 1981 but only on 3 February 1981. The deceased, he said, was not a case requiring his immediate attention and there were five to ten such admissions daily. TPW3 told the Court that he diagnosed the matter as cerebral contusion where recovery was usually within 24 to 48 hours but where damage may last as long as eighteen months. The witness further said that there was no evidence of either a subdural, extradural or intracerebral haemotoma and no localising signs to suggest an intracranial compression although the deceased was unconscious initially.

TPW3 further gave evidence that from the records, the deceased had become conscious after admission but drowsy and by 3 February 1981 the deceased was showing signs of improvement; on 7 February 1981 he had no fever and was conscious, mildly drowsy and there was no neurological deficit; on 10 February 1981 his condition was the same as on 7 February 1981; on 12 February 1981 he was shouting abusive language and was put on tranquilisers; on 14 February 1981 the tranquilisers were stopped; on 19 February 1981 his condition was the same as on 14 February 1981 and on 7 February 1981; and he was discharged on 28 February 1981 as he was conscious, alert, rational, and his speech normal but disoriented with time and space, and that there was no neurological deficit.

TPW3 also testified that after the deceased's first discharge, he was seen by a Dr. Chee on 9 March 1981 where he was conscious and drowsy and there was no mention of localising signs, and by a Dr. Yusof on 23 March 1981 and 20 April 1981 where the deceased could answer questions. Before the deceased's second admission, TPW3 had referred him to a psychiatrist who said that there was post concussional syndrome and wanted to rule out chronic subdural haemotoma. Because of that, the deceased was readmitted on 25 April 1981.

In view of the psychiatrist's findings, TPW3 had intended to do a CAT scan but this was then only available in Kuala Lumpur. An appointment could not be arranged by 31 May 1981 and TPW3 decided to do the exploratory burr holes the result of which no evidence of any haemotoma was found. He maintained that there was no change of diagnosis as for the first admission but the deceased was better then that at the time of the two admissions. Although TPW3 wanted to give the deceased institutional care in the Machang District Hospital, the deceased's relatives preferred to bring him home resulting in the deceased's second discharge on 30 June 1981. TPW3 also said that the deceased was seen by Dr. Chee on 10 July 1981 where the deceased was able to talk and had no complaints.

Under cross-examination, TPW3 said that despite the note to call Kuala Lumpur for the CAT scan, he did not know if the minute was acted upon by Dr. Yusof. In any case, TPW3 did not agree that a CAT scan would have been more beneficial. In fact, he was of the opinion that it was not necessary. The earlier decision for one, he added, was only on ethical grounds in view of the psychiatrist's conclusions.

I shall first deal with the question of quantum. As regards the special damages claimed by the plaintiff, I would allow the RM500 claimed for funeral expenses under item (a) as apart from the plaintiff's evidence that she had spent this amount, it was a reasonable and

appropriate amount to spend for a Muslim funeral. I would also grant the prayer of RM350 for the letters of administration as this is the usual figure. For item (c), since the agreed bundle of documents (A) only includes the receipts for the medical report (RM20), police and sketch plan reports (RM6) and the RIMV report (RM10) but not for the second police report in the bundle of documents not agreed (B) for RM2, the Court makes an award for RM36 only. Although there is no clear evidence as regards the damage to the bicycle apart from the plaintiff's testimony, I would still allow the RM100 claimed as being a fair amount to award from the loss of the bicycle. Considering the fact that the deceased spent some time in hospital, I also awarded the plaintiff RM150 claimed under item (e) for her transport expenses to go to the hospital to visit the deceased.

For loss of expectation of life, the award would be RM6,000 as this figure had been agreed to by Counsel for the plaintiff and the defendant in their submissions which amount in any case is in line with the present awards under this head in view of the Supreme Court decision in *Teoh Kim Seng v. Hassan bin Mohamed & Anor.* [1987] CLJ (Rep) 390. For loss of dependency, the RM250 a month stated by the plaintiff as being the amount given to her by the deceased has not been seriously contested and based on a multiplier of 55 minus 42 and taking away another one-third for contingency (4) resulting in 9, the award would be RM21,323.47 sen based on the annuity tables. However, in view of the reasoning enunciated in *Thangavelu v. Chia Kok Bin* [1981] 1 CLJ (Rep) 281, I would make an award of RM250 times the 7 years 2 months' pretrial period amounting to RM21,500 added to RM250 with the remaining multiplier of 2 which comes to RM5,580 following the annuity tables and rounded up to the nearest round figure. This gives a total of RM27,080. The award for loss of future earnings would be RM365 on a multiplier of 9 which gives a figure of RM31,150 to the nearest. As this is higher than the loss for dependency, I would grant this award of RM31,150 for the lost years.

Learned Counsel for the plaintiff had also submitted that since death was not immediate, an award should be made for pain and suffering and loss of amenities. I entirely agree with this submission and without any serious contest from the other two Counsels, I made an award of RM15,000 under this head for the period of 5 months 18 days from the accident to the date of death considering the RM20,000 award made in *Thangavelu v. Chia Kok Bin* [1981] 2 MLJ 277, *supra* for a period of 11 months and 6 days.

It is now necessary to determine the question of liability. As between the plaintiff and the defendant, the Court accepts the fact that the deceased had cut across the path of the defendant about 30 feet away but is of the view, especially because the defendant had noticed the deceased from a distance 60 feet away, that this was a far enough distance for the defendant to have anticipated the possibility of the deceased cutting across and to have been able to avoid the collision. He should therefore be found contributory liable based on *Ho Kiong Chan v. Patipet* [1966] 1 MLJ 1593, *Chan Peng Fook v. Kan Pak Lee* [1974] 2 MLJ 197, and *Joginder Kaur & Anor. v. Malayan Banking Ltd. & Anor.* [1971] 1 MLJ 98. I was, however, of the opinion that the deceased was more to blame as there would have been no accident if he did not cut across in that manner. On the facts adduced, I would apportion liability as against the plaintiff 60% and as against the defendant 40%.

Since it is not in dispute that the deceased did not die a natural death, the next question is whether the deceased died as a result of the accident contributed by his own negligence and that of the defendant or was it due to the negligence of the third party in managing him as a patient. As for the first third party (TPW2), my opinion is that he had been wrongly

cited as it is obvious that he was not involved in the active management of the deceased despite his signatures on the records which happened to be so as he was in fact assisting TPW3. However, he had found no improvement of the deceased on the second admission and up to the second discharge and was of the view that no purpose would be served by doing a CAT scan on the deceased as the exploratory burr holes had showed that the damage was permanent.

TPW1 had categorically given evidence that between the dates of the first admission and discharge on 31 January 1981 and 28 February 1981 respectively, there were no manifestations of a blood clot and agreed with the decision of TPW3 to discharge the deceased the first time as there was no deterioration and in fact there had been some improvement. He added that the deceased's head chart was steady and that there were no abnormal signs in the nervous system.

TPW3 had told the Court that he had not attended immediately to the deceased on admission as it was not necessary and in any case there were five to ten such cases daily. He had diagnosed the deceased as having cerebral contusion where recovery could be as early as 24 to 48 hours or as long as eighteen months. He found no evidence of a subdural, extradural or intracerebral haematoma or intracranial compression.

He had subsequently discharged the deceased the first time as he found him to be conscious, alert, rational, normal in speech although disoriented with time and space and having no neurological deficit. Between his first discharge and second admission, the deceased had attended three follow-up check-ups where he was found to be conscious and was in a position to answer questions. He was also referred to a psychiatrist which diagnosed it as post traumatic psychosis. To rule that out, exploratory burr holes were done where no lesion or blood clot, that is, no subdural haematoma was found in the brain. TPW3 had then suggested to the deceased's relatives that he be given institutional care at the Machang District Hospital but this was refused and so the patient was discharged the second time on 30 June 1981. He had one follow-up check-up on 10 July where he was able to talk but he died on 18 July 1981.

DW2, who was at the relevant time working at the Kuala Lumpur General Hospital was of the view that the deceased should have been sent for a CAT scan which was then not available in Kota Bharu to get further information, as regards the blood clot and state of fluids in the brain, to further manage the patient. A CAT scan, he added, would have enabled a more definitive approach. He, however, agreed that if all investigations had ruled out the presence of a structural abnormality responsible for the state of the deceased, it was all right to discharge the deceased provided he had proper nursing care. On this point, it must be noted that TPW3 did suggest to the deceased's relative to place him at the Machang District Hospital but this had been rejected.

In *Lanphier v. Phipos* [1838] C & P 475 the Court had ruled that:

> Every person who enters into a learned profession undertakes to bring to the exercise of it a reasonable degree of care and skill. He does not undertake, if he is an attorney, that at all events you shall gain your case, nor does a surgeon undertake that he will perform a cure; nor does he undertake to use the highest possible degree of skill. There may be persons who have higher education and great advantages than he has, but he undertakes to bring a fair, reasonable and competent degree of skill, and you will say whether, in this case, the injury was occasioned by the want of such skill in the defendant.

In *Rich v. Pierpont* [1862] 3 F & F 35 Erle CJ had succinctly stated that:

> A medical man was certainly not answerable merely because some other practitioner might possibly have shown greater skill and knowledge; but he was bound to have that degree of skill which could not be defined, but which, in the opinion of the jury was a competent degree of skill and knowledge.

These cases were heard in 1838 and 1862 respectively. In 1925, in the case of *Hunter v. Hanley* [1955] SC 200, which was an appeal by a medical practitioner against his conviction for manslaughter arising out of the death of a patient, the Court's view was:

> But where the conduct of a doctor, or indeed of any professional man, is concerned, the circumstances are not so precise and clear cut as in the normal case of negligence. In the realm of diagnosis and treatment there is ample scope for genuine difference of opinion and one man clearly is not negligent merely because his conclusion differs from that of other professional men, nor because he has displayed less skill or knowledge than others would have shown. The true test for establishing negligence in diagnosis or treatment on the part of a doctor is whether he has been proved to be guilty of such failure as no doctor of ordinary skill would be guilty of if acting with ordinary care...

In *Jones v. Great Western Railway Company* [1931] (House of Lords) The Law Times Vol. 144 194 Lord Macmillan in a dissenting judgment pronounced that:

> The dividing line between conjecture and inference is often a very difficult one to draw. A conjecture may be plausible, but it is of no legal value, for its essence is that it is a mere guess. An inference in the legal sense, on the other hand, is a deduction from the evidence, and if it is a reasonable deduction it may have the validity of legal proof. The attribution of an occurrence to a cause is, I take it, always a matter of inference. The cogency of a legal inference of causation may vary in degree between practical certainty and reasonable probability.

In *R. v. Bateman* [1925] 94 LJ KB 791 the Court opined that:

> A doctor's duty towards his patient is that he has to exercise a fair and reasonable standard of care and skill, i.e. the skill of an ordinarily competent medical practitioner.

Learned Counsel for the defendant had also referred to the judgment in *Hunter v. Hanley* [1955] SC 200, *supra*, which stated:

> ... To establish liability by a doctor where deviation from normal practice is alleged, three facts require to be established. First of all, it must be proved that there is a usual and normal practice; secondly it must be proved that the defender has not adopted the practice and thirdly (and this is of crucial importance) it must be established that the course the doctor adopted is one which no professional man of ordinary skill would have undertaken if he had been acting with ordinary care

and to *Clark v. MacLennan & Anor.* [1983] 1 All ER 416 where the Court had expressed the following:

> Where however there is but one orthodox course of treatment and he chooses to depart from that, his position is different. It is not enough for him to say as to his decision simply that it was based on his clinical judgment. One has to inquire whether he took all proper factors into account which he knew or should have known, and whether his departure from the orthodox course can be justified on the basis of these factors.

In *Bolam v. Frier Hospital Management Committee* [1957] 1 WLR 583 McNair J had declared that:

> The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest skills, it is well established that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art.

On these considerations, I was of the opinion that as far as the first third party was concerned, he had been wrongly cited. TPW3 should have been the first third party. Be that as it may, since the death of the deceased was eighteen days after his second discharge having been hospitalised for about two months and after a proper regular check-up about eight days earlier where the deceased was able to talk, because no post-mortem had been conducted, and also because TPW3 had satisfactorily explained his conclusions, the Court held that no legal inference can be made on the facts as they stand upon a balance of probabilities that the third party was liable in negligence. Even DW2 could not categorically state that TPW3 had been wrong in his diagnosis. He had only opined that a CAT scan in Kuala Lumpur would have enabled the authority to manage the deceased better.

At the most, DW2's testimony remains a matter of opinion. There is no cogent evidence that TPW3 had departed from the approved practice in treating the deceased. TPW3 had been attending to the deceased throughout and had diagnosed the matter as a cerebral contusion where the recovery could take as long as eighteen months. He had found it fit to discharge the deceased on both occasions being of the opinion that, in view of the progress of the deceased, nothing else could be done. He had even recommended institutional care for the deceased after the second discharge. Both the discharges had been followed with follow-up check-ups where the deceased was able to talk. In short, TPW3 had treated the deceased in the same way he had treated other patients in similar condition which according to him were not that rare considering the five to ten such admissions daily. In the event, he had not sent the deceased for a CAT scan which he said was neither necessary nor beneficial.

In the circumstances, I would find the plaintiff 60% liable, the defendant 40% liable and the third party not liable for negligence. In the event, the Court awards the plaintiff, on 100% liability, special damages of RM1,136 with interest at 4% from the date of accident to the date of judgment and general damages totalling RM52,150, made up of RM6,000 for loss of expectation of life, RM31,150 for the lost years and RM15,000 for pain and suffering and loss of amenities, with interest at 8%, except for the future loss, from the date of service of the writ to the date of judgment and costs. The defendant is to pay the costs of the third party. As usual, all costs are to be taxed accordingly.

Also found at [1989] 2 CLJ 1232